Client Intake Form

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

Name: _____ Date: _____

Address: _____

Cell Phone: _____ May we leave a message? Yes No

Email: _____

DOB: _____ Age: _____

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

How did you hear about or find this practice? _____

Have you previously received any type of mental health services? Yes No

If yes, please list previous therapist/practitioner: _____

Are you currently taking any prescription medication? Yes No If yes, please list:

_____

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

Are you currently experiencing overwhelming sadness, grief or depression? Yes No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? Yes No

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? Yes No

If yes, please describe: _____

Do you drink alcohol more than once a week? Yes No

Are you currently in a romantic relationship? Yes No

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

What significant life changes or stressful events have you experienced recently?

_____

Are you currently employed? Yes No

If yes, what is your current employment situation and where do you work?

_____

Do you enjoy your work? Yes No

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

Is there any other information that might be helpful?

_____

_____